641—201.8(135,75GA,ch158) Accountability. Accountability measures shall be in place to ensure access and quality of care. Each ODS shall provide information to the department on measures of quality, access, member satisfaction, membership and utilization, finance, and management. The department shall publish annually, by November 1 of each year, the indicators that will be required for the reporting year in a document that shall be shared with all licensed ODSs as well as all applicants. Indicators shall be based upon nationally recognized, documented standards.

201.8(1) *Quality.* The department shall establish indicators to measure the quality of care provided by an ODS.

201.8(2) *Access.* The department shall establish indicators of access to care within an ODS. At least one of the indicators shall be the ratio of primary care providers to enrollees by category of provider.

201.8(3) *Member satisfaction.* The following shall be reported by the ODS to demonstrate member satisfaction.

a. Percent of members indicating overall satisfaction with plan from a member survey.

b. Submission of a copy of the member satisfaction survey used by the ODS.

201.8(4) *Membership and utilization.* Indicators of utilization shall be established by the department for costs, frequency of procedures, inpatient and outpatient services. Indicators of membership shall include the following:

a. Member months stratified by age, gender, residence, and purchaser.

b. Disenrollments by month stratified by age, gender, residence, and purchaser.

201.8(5) *Finance.* Indicators of financial stability and solvency shall be reported according to the standard established in rules 201.12(135,75GA,ch158) and 201.13(135,75GA,ch158).

201.8(6) *Management practices.* Management practices shall be described for the following areas:

a. Credentialing. The ODS shall describe its credentialing process as provided for in 201.6(1).

b. Points of service. The ODS shall provide information on the location of providers, including primary care providers, specialty providers, and hospitals, as provided for in 201.5(4).

c. Quality assessment and improvement activities.

d. Case management.

e. Risk management.

f. Community needs assessments.

g. Relationships with essential community providers.

h. Efforts to address the needs of underserved populations and geographic areas.